North Dakota Suicide Prevention Plan

2005

North Dakota Suicide Prevention Plan

A Publication of:

North Dakota Department of Health
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DEVELOPED BY:
The North Dakota Suicide Prevention Task Force

PREPARED BY:
DLN Consulting, Inc.

SEPTEMBER 2005

NORTH DAKOTA SUICIDE PREVENTION PLAN
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PREFACE

Introduction

Suicide prevention programs should be:

- Designed to enhance protective factors and work toward reversing or reducing known risk factors.
- Long-term, with repeat interventions to reinforce the original goals.
- Family-focused to have a greater impact than only individual-focused programs.
- Adapted to address the specific nature of the problem in the local population group.
- More intensive in the higher risk-level population and should start earlier than this target age group.
- Age-specific, developmentally appropriate, and culturally sensitive.
- Implemented with no or minimal difference from how they were designed and tested.
- Community programs that include media campaigns and policy changes to be more effective when individual and family interventions accompany them.
- Community programs that strengthen norms that support help-seeking behavior in all settings, including family, work, school and community.

Once a suicide prevention strategy is implemented, it is only effective if it is evaluated, shared with others, and modified to meet the changing needs of each community.

Keeping this important information in mind, the North Dakota Suicide Prevention Task Force worked together to develop an effective state suicide prevention plan. The first step of developing this plan was a brainstorming session to identify priority areas for strategy development that would be most likely to reduce injury and death from suicidal behavior. Once the many priority areas were refined into four main areas by a process of strategic planning, the task force began writing goals and strategies for these areas. When writing strategies, the task force determined the potential effects of each strategy, including social, legal, ethical and economic effects. Optimal methods for implementing the strategies also were considered. The task force members also worked together to develop a mission statement to describe their purpose and what they hoped to accomplish.

This document and its contents are a result of the input and cooperation of the North Dakota Suicide Prevention Task Force members. It is intended to be a lucid document that will be periodically assessed for effectiveness as it is developed and implemented.

Lead Agency

The Mental Health Association in North Dakota (MHAND) and the North Dakota Department of Health Injury Prevention Program are the lead agencies for the North Dakota Suicide Prevention plan and the overseers of the North Dakota Suicide Prevention Task Force.

NORTH DAKOTA
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September 2005

To Our Partners in Suicide Prevention:

Nationally and in North Dakota, suicide is a leading cause of death. From 1994 to 2003, 797 North Dakotans died from suicide. This report addresses this serious, yet preventable, public health problem.

It is unclear why North Dakotans reach a point in their lives where suicide becomes an option to relieve their pain, but several key risk factors have been identified. Factors include loneliness and isolation, depression, mental illness, bullying, access to lethal means, alcohol and other drug abuse, historical trauma, stigma about seeking help, and limited access to mental health services.

The North Dakota Department of Health, Injury Prevention Program, works closely with the Mental Health Association in North Dakota and other partners to reduce the number of suicides and suicide attempts. We are committed to the mission of the Suicide Prevention Task Force to "empower communities to reduce injuries and deaths resulting from suicidal behavior."

We hope this document will provide an in-sight into the depth of suicide in North Dakota and offer some helpful prevention strategies.

Sincerely,

Terry L. Dwelle, MD, MPHTM
State Health Officer

TLD/CM:lrr

MENTAL HEALTH ASSOCIATION IN NORTH DAKOTA

Works for a world free from discrimination against mental illness

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United Way

North Dakota 2-1-1 Get Connected. Get Answers.

Visit our website at
www.mhand.org

A private, non-profit 501(c) 3 agency. The only non-governmental organization concerned with all aspects of mental health for all citizens of North Dakota.

September 22, 2005

Carol Meidinger, Injury Prevention Program Director
North Dakota Department of Health
State Capitol
Bismarck, ND

Dear Ms. Meidinger:

As Executive Director of the Mental Health Association in North Dakota it is my pleasure to offer my strongest support to the new North Dakota Suicide Prevention Plan in 2005. This plan is designed to address suicide prevention across the entire lifespan. Suicide continues to be the 2nd leading cause of death for youth and young adults in North Dakota and ranks as the 8th leading cause of death for all age groups.

In 1999, North Dakota drafted their first state suicide prevention plan designed to address teen and young adult suicides. The initial adolescent suicide prevention plan provided the focus to begin the North Dakota Adolescent Suicide Prevention Project and a massive strategic public health campaign across North Dakota targeting teens and young adult suicides.

The results and outcomes were impressive. Dozens of entities and hundreds of individuals partnered in this effort, resulting in 35,000 individuals receiving suicide prevention training and the initiation of key suicide strategies available in every corner of North Dakota. From 2000-2004 suicide teen and young adult suicide fatalities dropped 35%. The project was nationally recognized in 2005 by receiving the highly prestigious Public Health Practice Award from the American Public Health Association highlighting this project as one of the nation's best public health efforts.

With a successful start against many challenges, the first five years of this project has become a national model for leaders of state, tribal, non-profit, community, faith-based, survivors, and teen organizations. The model demonstrates what leaders can do together when a sound plan, vision and funding are available. As we look to the next five years, we hope this plan will guide the many partners making up the North Dakota Suicide Prevention Task Force. We know survivors will take comfort and heart in the successful work being done and we hope that policy makers will be inspired to support and fund this much needed public health effort.

Sincerely,

Susan Rae Helgeland, MS
Executive Director

IHS NATIONAL TRIBAL STEERING COMMITTEE
FOR INJURY PREVENTION

Dennis A. Renville, Chairman
Jennifer Falck, Vice Chairperson
Linda Azule, Secretary
Elaine Boyd, Treasurer

Phone 701-255-3285 x 1374
Fax: 701-530-0606
E-mail: drenville@utte.edu

September 13, 2005

To Our Partners in Suicide Prevention:

I am pleased to write a letter of recommendation for you on the war against suicide. American Indians and Alaska Natives have the highest suicide rates in the country and presently the Standing Rock Sioux Tribe is facing an epidemic, as are several other reservations in North Dakota as well as some of rural North Dakota areas.

It is unclear why American Indians and North Dakotans reach a point in their lives where suicide becomes an option to relieve their pain, but several factors have been identified. These factors include depression, mental illness, bullying, access to lethal means, alcohol and other drugs, loneliness and isolation, depression, historical trauma, and very limited access to mental health services.

The National Tribal Steering Committee for Injury Prevention works closely with tribes and tribal organizations, and federal and state agencies in attempt to reduce injury morbidity and mortality to all Americans, including American Indians and Alaska Natives. We are committed to saving lives and bringing more resources to the rural and tribal communities to reduce injuries and deaths among our citizens resulting from suicidal behavior.

We hope this document will provide an in-sight into the depth of suicide in North Dakota and offer some prevention strategies.

If you have any questions, please feel free to call me at 701255-3285, extension 1374.

Sincerely,

Dennis A. Renville, Chairman
National Tribal Steering Committee for Injury Prevention

NORTH DAKOTA SUICIDE PREVENTION TASK FORCE MISSION

“Empower communities to reduce injuries and deaths resulting from suicidal behavior”

HISTORY AND EPIDEMIOLOGY

The History of Suicide Prevention in North Dakota

In 1999, the North Dakota Adolescent Suicide Prevention Task Force was formed. Initial state surveys and data analysis were completed. The data indicated suicide fatalities for 10- to 24- year-olds in North Dakota were almost twice the national rate. Additionally, North Dakota's suicide fatalities for the elderly were significantly less than the national average. Because of this information, a targeted population of adolescents and young adults became the primary focus for North Dakota's suicide prevention efforts when the first state plan was developed with recommendations for action. The plan was a holistic approach to suicide prevention with three overall strategies:

- Awareness and education
- Increased treatment access
- Resiliency and asset building

The first phase, the Awareness Phase, was begun in 2000 with the Mental Health Association of North Dakota becoming the lead agency in a $75,000 grant project. All of North Dakota's state regions and tribal areas were offered awareness and planning workshops. Overall, there were 126 workshops with 2600 participants. To date, more than 29,000 participants have attended workshops and technical assistance sessions to implement the recommended suicide prevention strategies.

In 2001, the grant project begun in the previous phase was successful, and the Mental Health Association of North Dakota was awarded $75,000 to coordinate the state suicide project. With this funding, the Action Phase began with the development of strategies in five core areas:

- Infrastructure
- Youth development
- Professional education
- Public education
- Evaluation

Capacity building began in 2002. Three regions funded part-time suicide prevention coordinators, and funding in the amount of $80,000 was received from five grant sources to continue state coordination efforts.

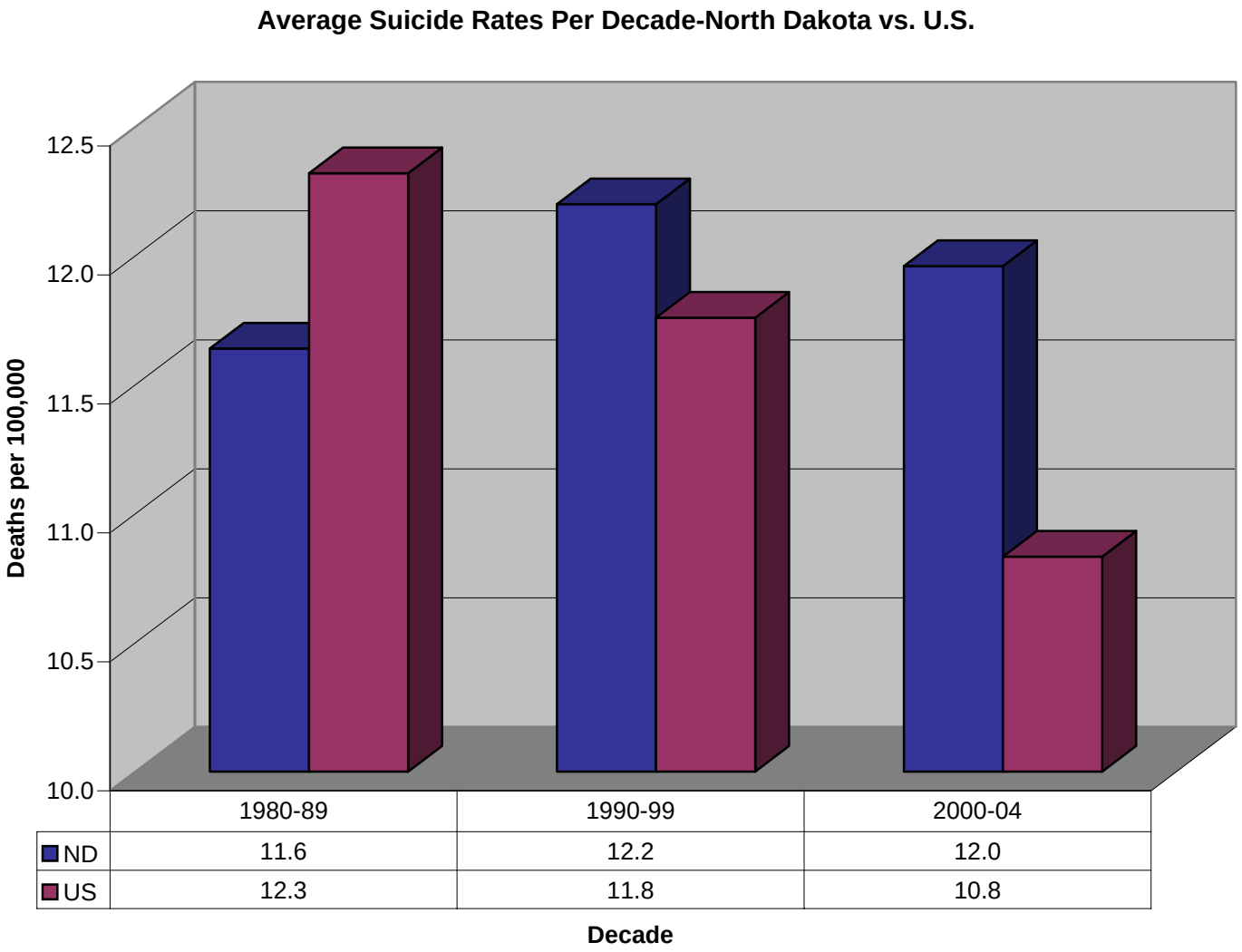
By 2003, eight rural and tribal mentoring coordinators had been hired with an $180,000 per year Safe and Drug Free School grant. A rapid community mobilization system was developed for targeted prevention response to suicide contagion or impact areas. This system included mentoring, support groups, screening efforts, crisis response, and teen-led efforts such as gatekeeper programs.

In 2004, the North Dakota Suicide Prevention Conference was held to focus on action efforts. Expansion was a result. Regional training of the rapid community mobilization system was instituted. The infrastructure was expanded through partnerships with local, regional and statewide groups. Stakeholders and suicide survivors began to be involved in legislative funding efforts. At this time, expanding the state suicide prevention plan to include all ages was also considered.

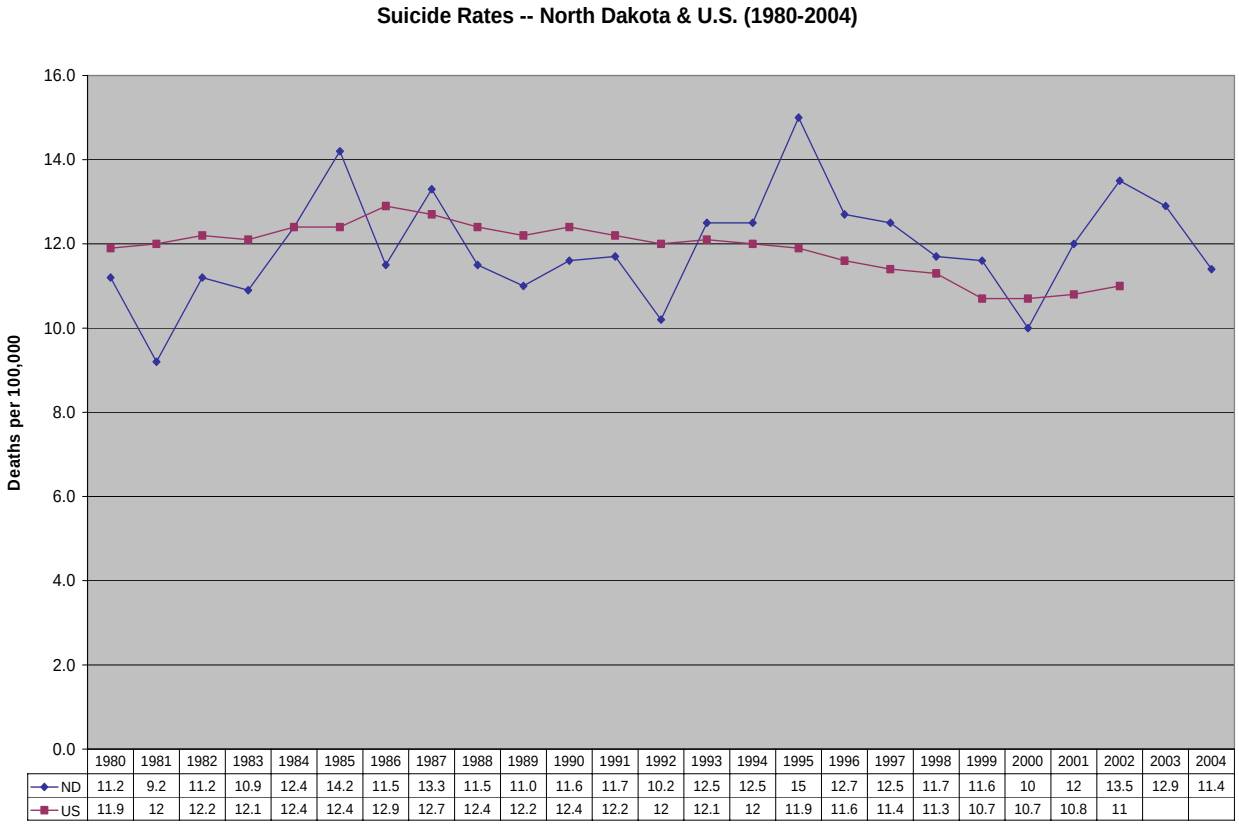
In May 2005, the Suicide Prevention Task Force met to begin the process of updating the North Dakota Suicide Prevention Plan. After reviewing and analyzing updated and trend data, the decision was reached to formulate a more comprehensive suicide prevention plan. Following a strategic planning process, the current Suicide Prevention Plan was developed.

A Look at 25 Years of Suicide Data, 1980-2004

When the Suicide Prevention Task Force gathered the information and statistics about suicide, United States suicide statistics were available through 2002. North Dakota suicide information and statistics were available through 2004. As a result, all information comparing North Dakota and U.S. statistics includes through 2004 for North Dakota and through 2002 for the United States.

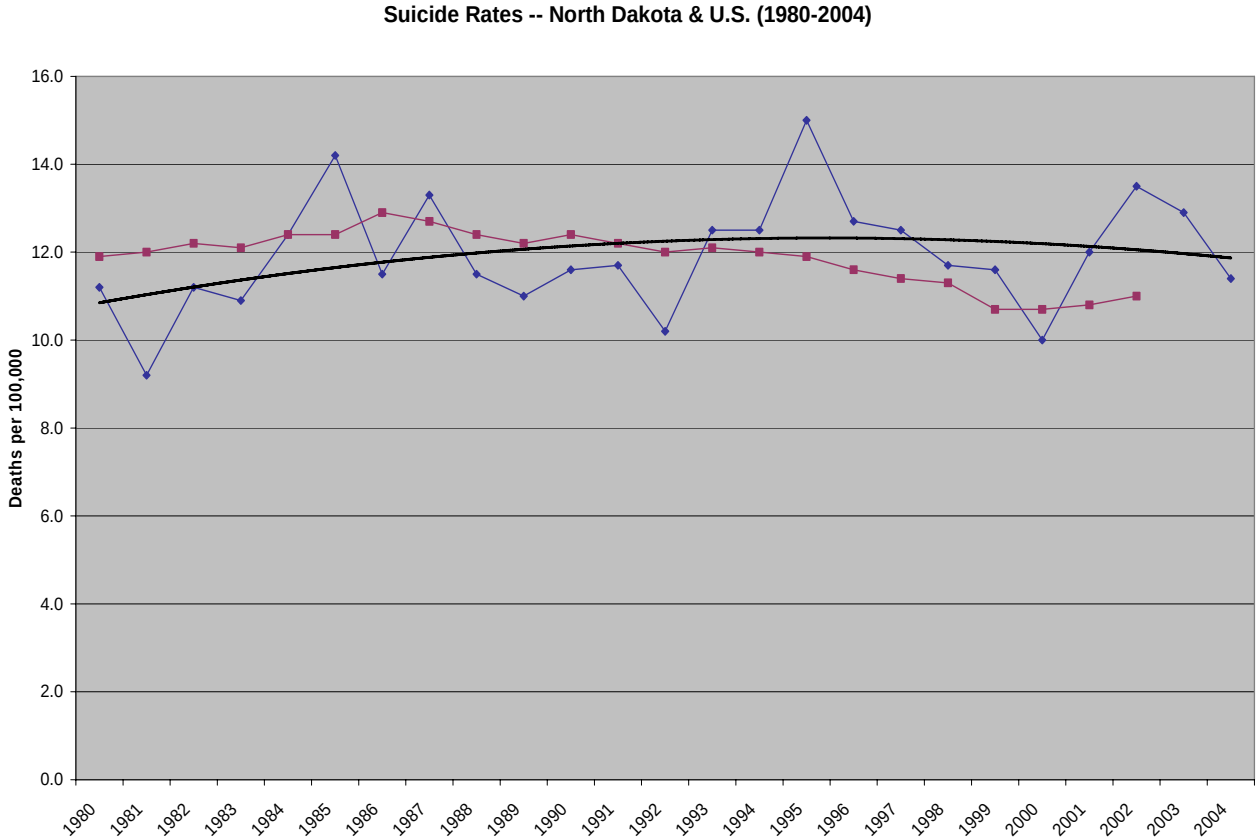


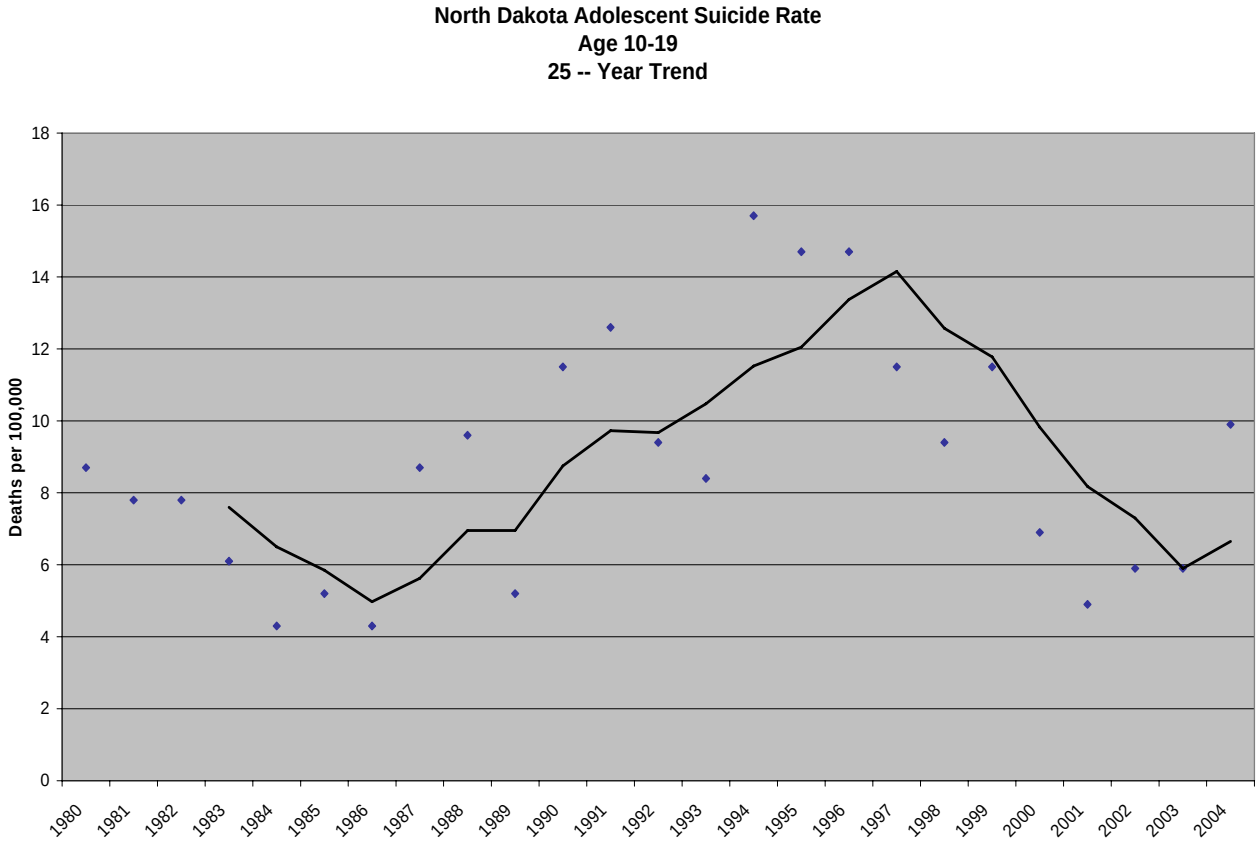
In 1998, 14 North Dakotans participated in the Suicide Prevention Advocacy Network Conference to help develop the first national suicide prevention plan. By 1999, the North Dakota suicide rate had surpassed the national rate for seven years in a row and averaged higher than the U.S. rate for the 1990-99 decade. In 1999, the North Dakota Adolescent Suicide Prevention Task Force was formed. Initial state surveys and data analysis were completed, and the first North Dakota State suicide plan was developed with recommendations. Since 1999, the overall North Dakota suicide rate has declined, but North Dakota is still far above the national rate.



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
ND	11.2	9.2	11.2	10.9	12.4	14.2	11.5	13.3	11.5	11.0	11.6	11.7	10.2	12.5	12.5	15	12.7	12.5	11.7	11.6	10	12	13.5	12.9	11.4
US	11.9	12	12.2	12.1	12.4	12.4	12.9	12.7	12.4	12.2	12.4	12.2	12	12.1	12	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11		

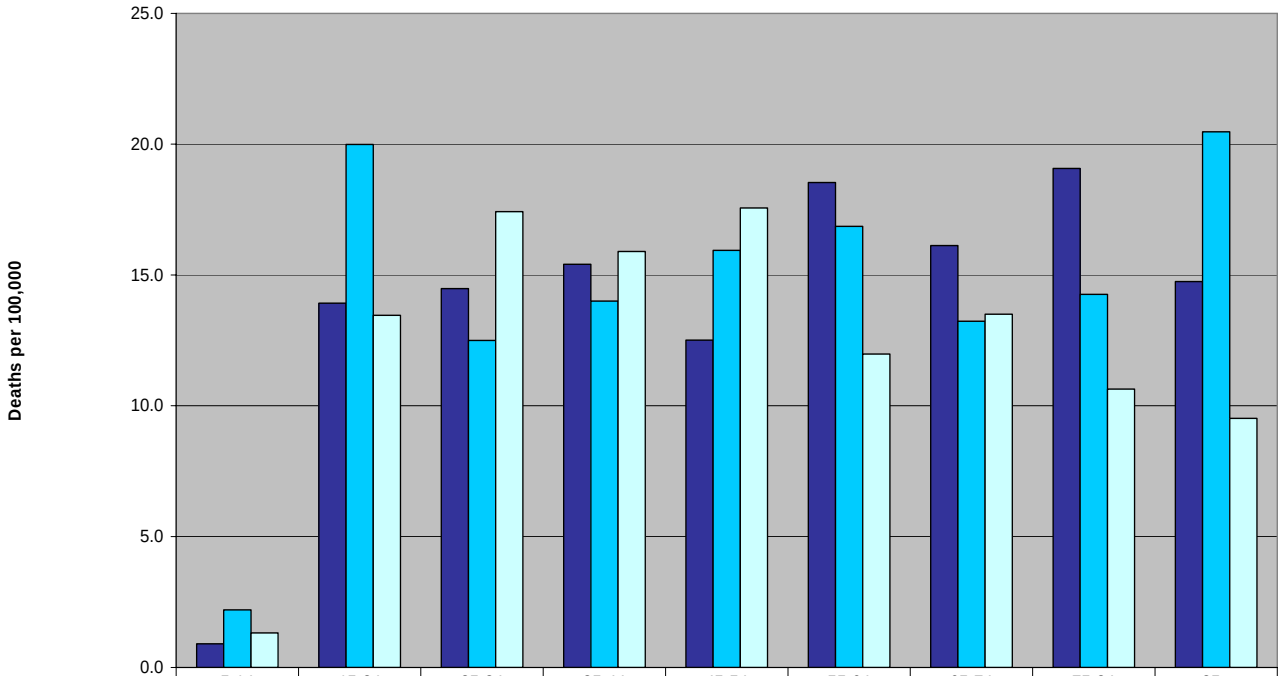
As demonstrated by the graph above, in the last 25 years of comparative data between the U.S. and North Dakota, the U.S. suicide rate per 100,000 has been on a downward trend and continues to decrease each year. The North Dakota rates, on the other hand, go up and down. When comparing the overall trend, however, it is evident that the rate of suicide in North Dakota has shown an upward trend per 100,000 in the last 25 years and has started to decrease only in the last four years. This is further demonstrated by the graph below, which includes a North Dakota trend line.





In 1999, adolescents and young adults became the primary target focus of the North Dakota Suicide Prevention Plan. At that time, the data indicated suicide fatality rates for the adolescent and young adult age groups were almost twice the national rate. Since then, a dramatic decrease has been observed in the 10- to 19-year-olds, as evidenced in the graph above.

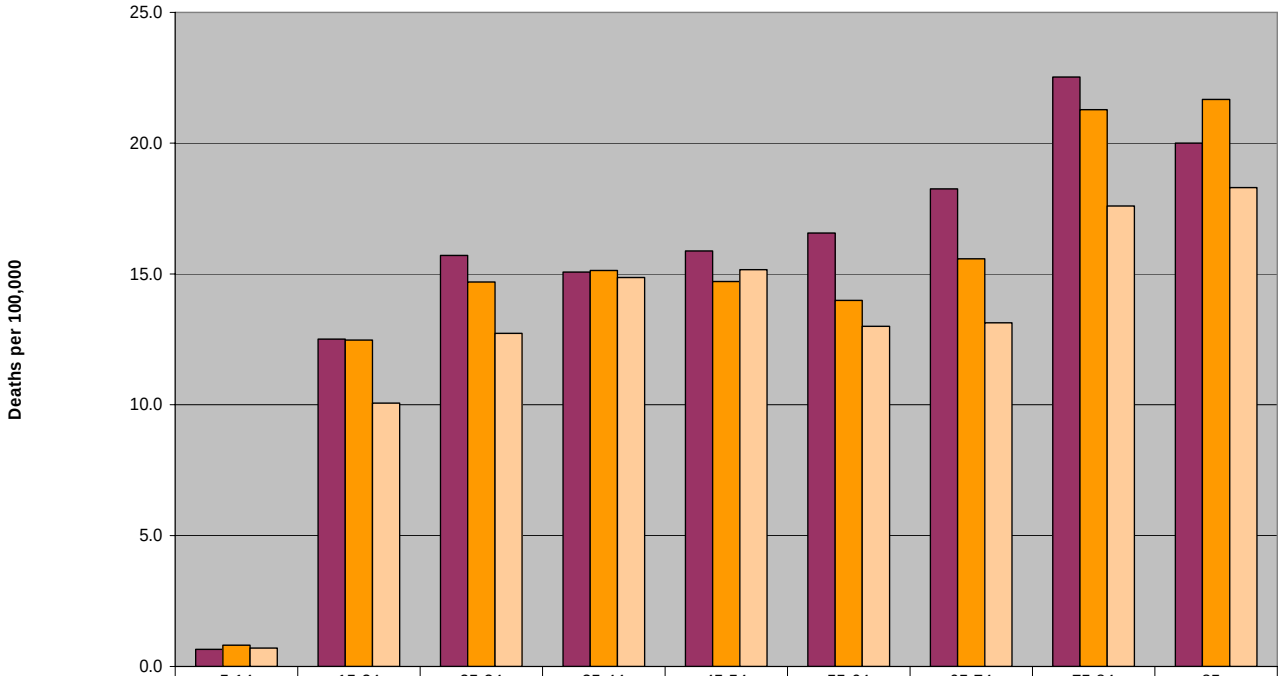
Average Suicide Rates per Decade by Age Group -- North Dakota



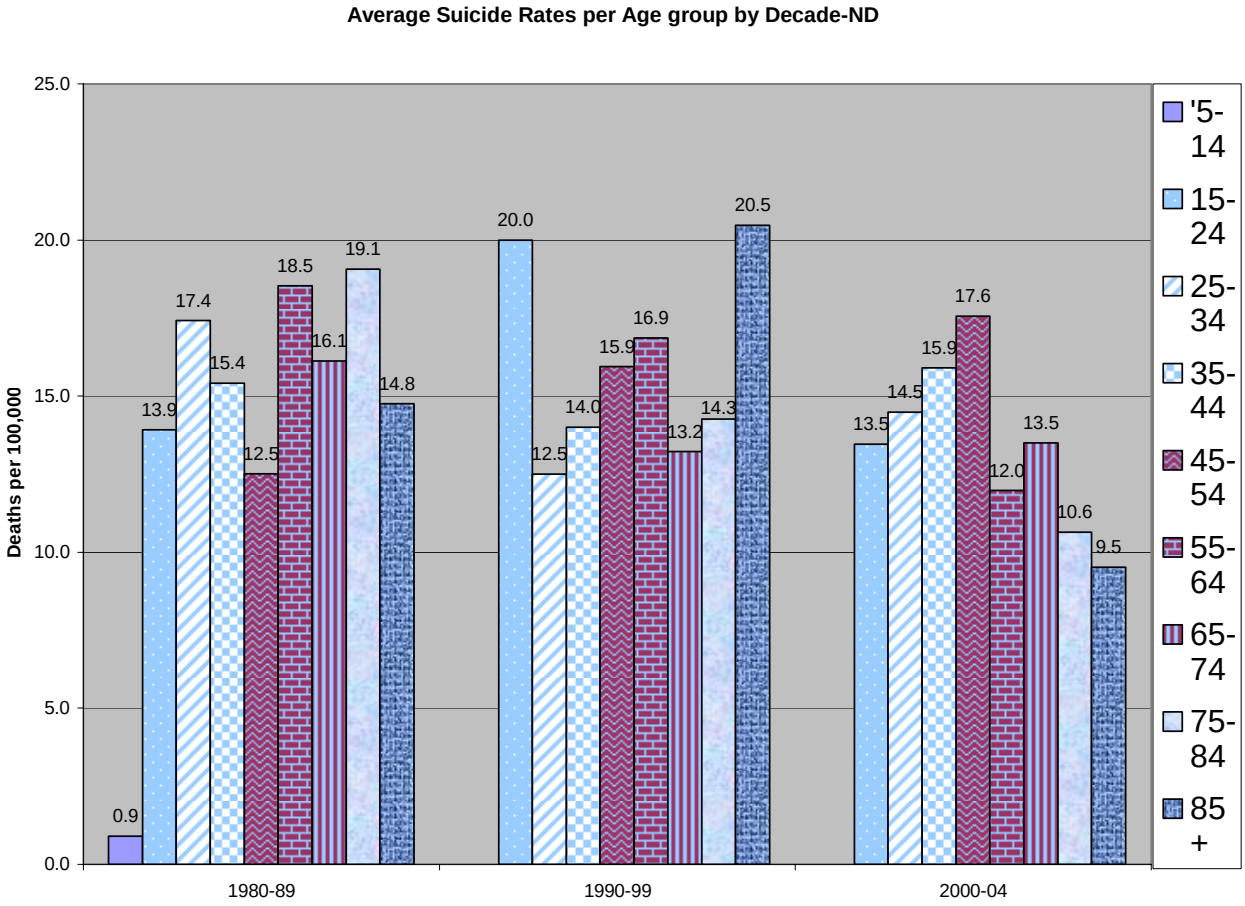
	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
ND avg 1980-89	0.9	13.9	14.5	15.4	12.5	18.5	16.1	19.1	14.8
ND avg 1990-99	2.2	20.0	12.5	14.0	15.9	16.9	13.2	14.3	20.5
ND avg 2000-04	1.3	13.5	17.4	15.9	17.6	12.0	13.5	10.6	9.5

North Dakota is now experiencing an upward trend in suicides in the middle-aged population of North Dakota, specifically the 25 to 34, 35 to 44, and 45 to 54 age groups. Due to this new trend, North Dakota has a need to expand its suicide prevention plan to encompass all ages.

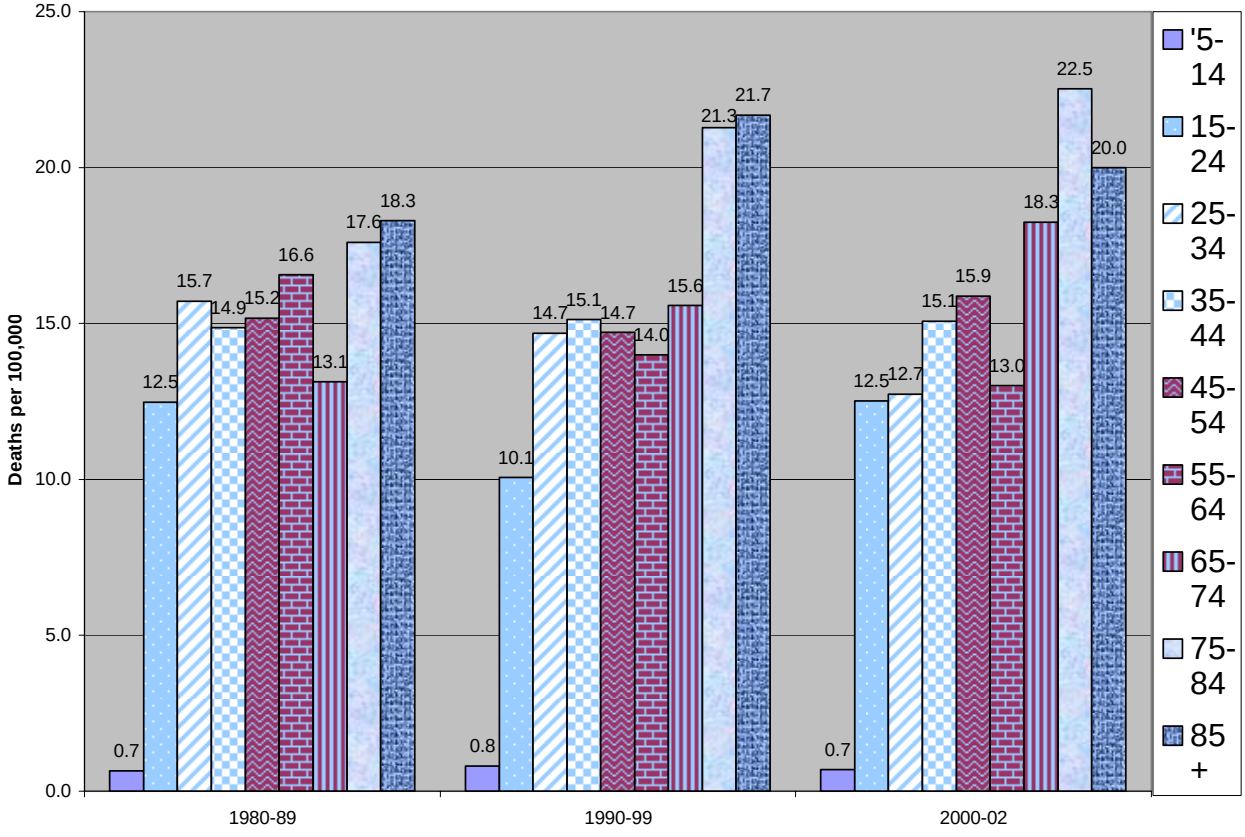
Average Suicide Rates per Decade by Age Group -- U.S.



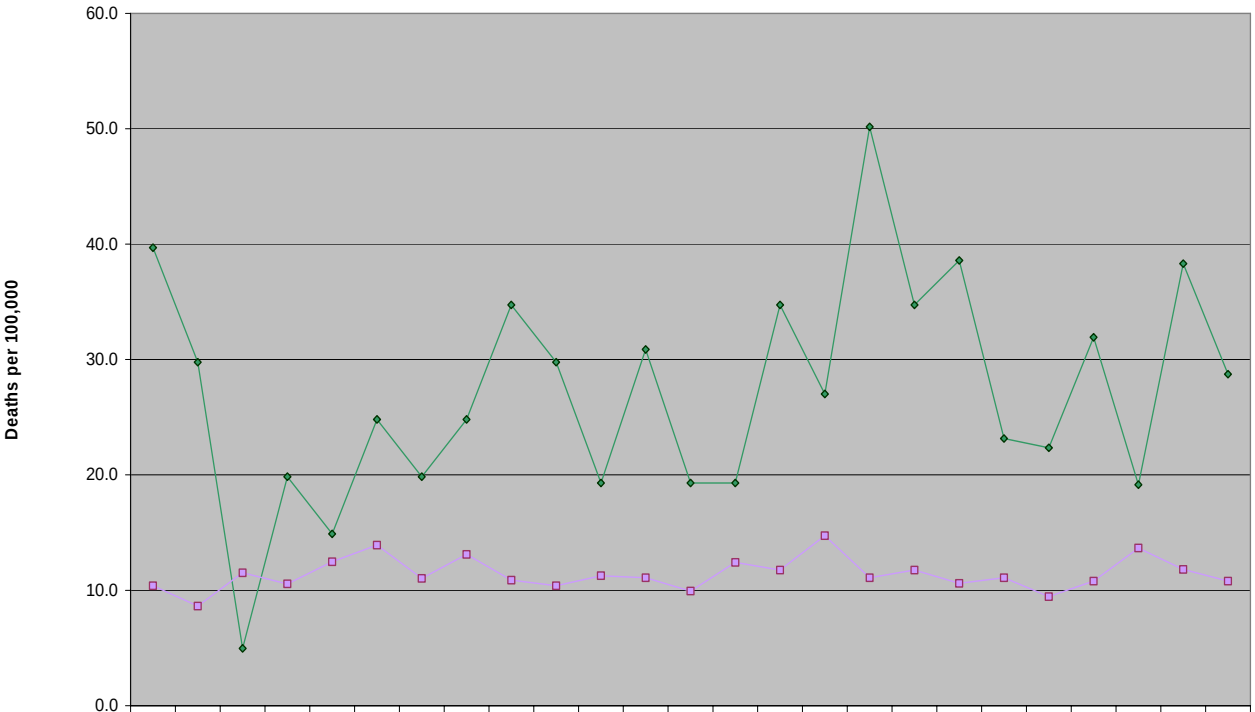
	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
US avg 1980-89	0.7	12.5	15.7	15.1	15.9	16.6	18.3	22.5	20.0
US avg 1990-99	0.8	12.5	14.7	15.1	14.7	14.0	15.6	21.3	21.7
US avg 2000-02	0.7	10.1	12.7	14.9	15.2	13.0	13.1	17.6	18.3



These graphs depict each age group by decade grouped together and allow comparisons at a glance as to which age group(s) had the highest rates per decade. By evaluating the North Dakota graph (above) and U.S. graph (below) it is also possible to weigh the state rates against the national rates.



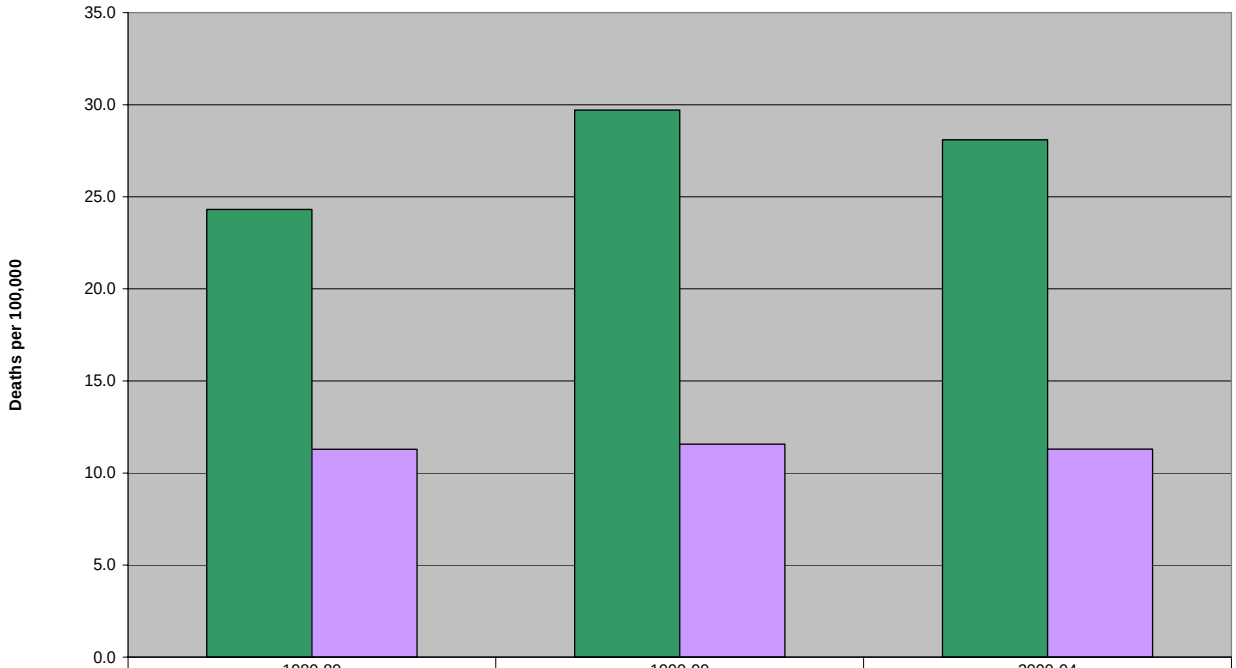
North Dakota Suicide Rates by Race (1980-2004)



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Native Am	39.7	29.8	5.0	19.8	14.9	24.8	19.8	24.8	34.7	29.8	19.3	30.9	19.3	19.3	34.7	27.0	50.2	34.7	38.6	23.2	22.3	31.9	19.2	38.3	28.7
White	10.4	8.6	11.5	10.6	12.5	13.9	11.0	13.1	10.9	10.4	11.3	11.1	9.9	12.4	11.8	14.7	11.1	11.8	10.6	11.1	9.4	10.8	13.7	11.8	10.8

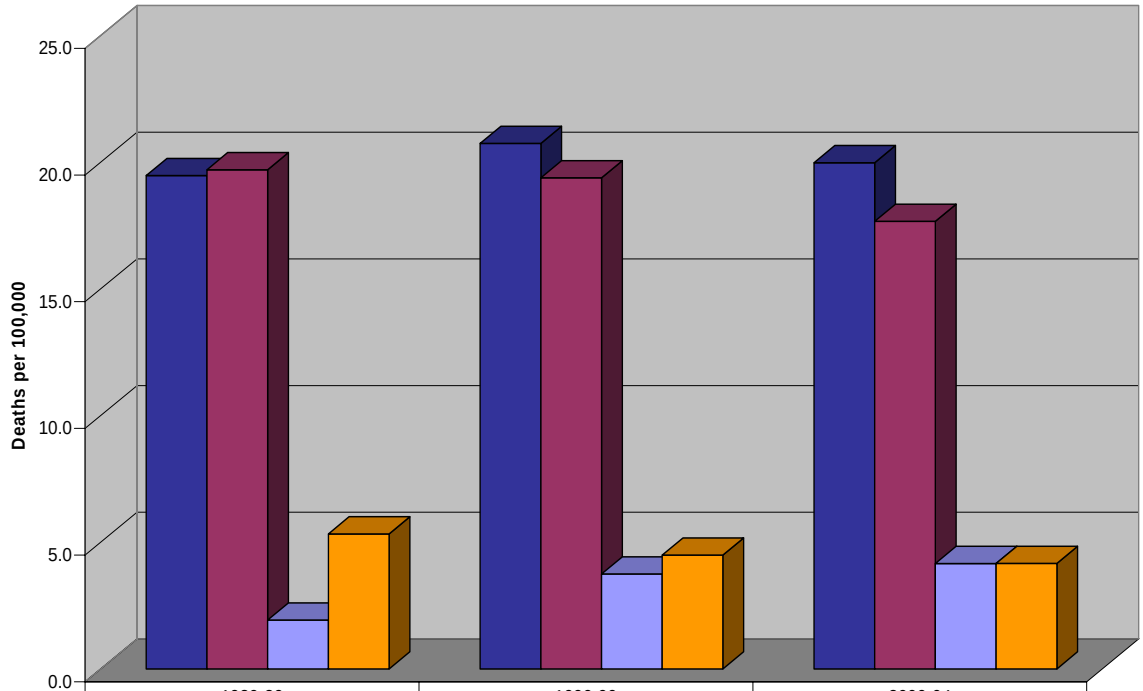
Native American youth and young adults were also a primary focus for prevention efforts in 1999. The U.S. Bureau of the Census, 1990 Census of Population and Housing reported only 4.1 percent of North Dakota's population was Native American, yet Native Americans accounted for almost 10 percent of all North Dakota suicide fatalities. This is illustrated in the high suicide rates shown for the Native American population. As demonstrated in the graph below, the Native American suicide rate has historically been twice the rate of the white population per decade in the last 25 years.

North Dakota Suicide Rates by Race per Decade



	1980-89	1990-99	2000-04
Native Am	24.3	29.7	28.1
White	11.3	11.6	11.3

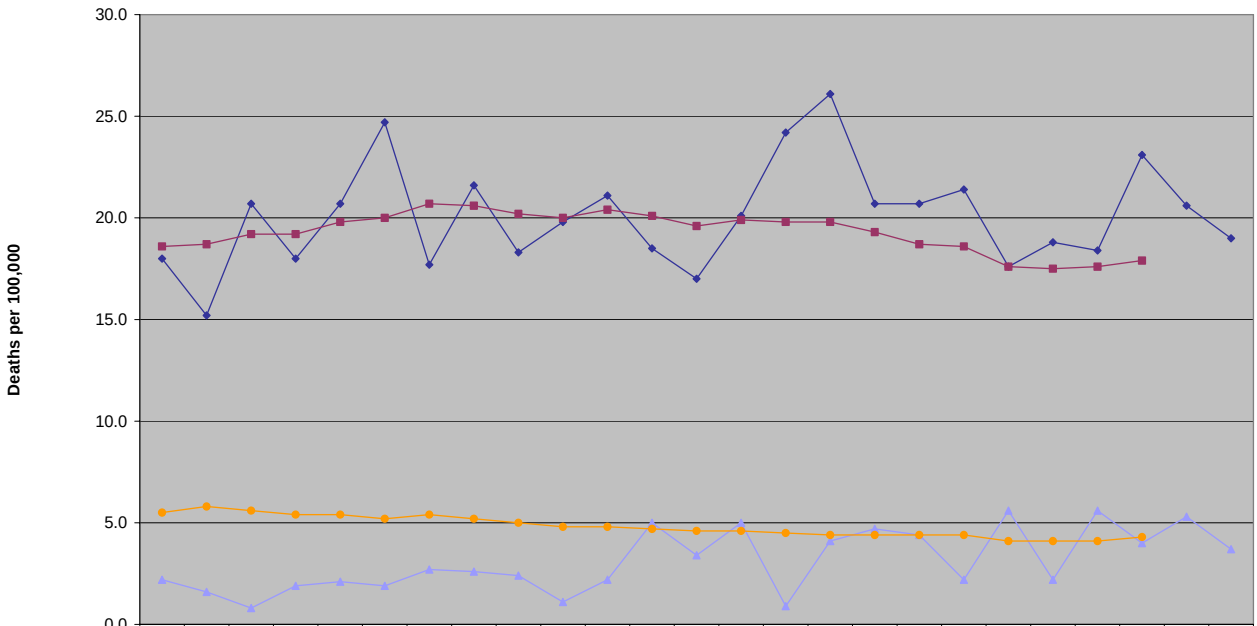
Average Suicide Rates by Gender per Decade -- North Dakota & U.S.



	1980-89	1990-99	2000-04
ND Male	19.5	20.7	20.0
US Male	19.7	19.4	17.7
ND Female	1.9	3.8	4.2
US Female	5.3	4.5	4.2

As evidenced by the graphs on this page, both North Dakota and national suicide rates for male populations are much higher than for females. Overall, the U.S. rates have decreased for both the male and female populations. In contrast, although North Dakota has observed a slight decrease in male rates in this decade, they are still above the national average, and the female suicide rates have increased steadily over the past 25 years, bringing North Dakota even with the national average.

Suicide Rates by Gender -- North Dakota & U.S. (1980-2004)

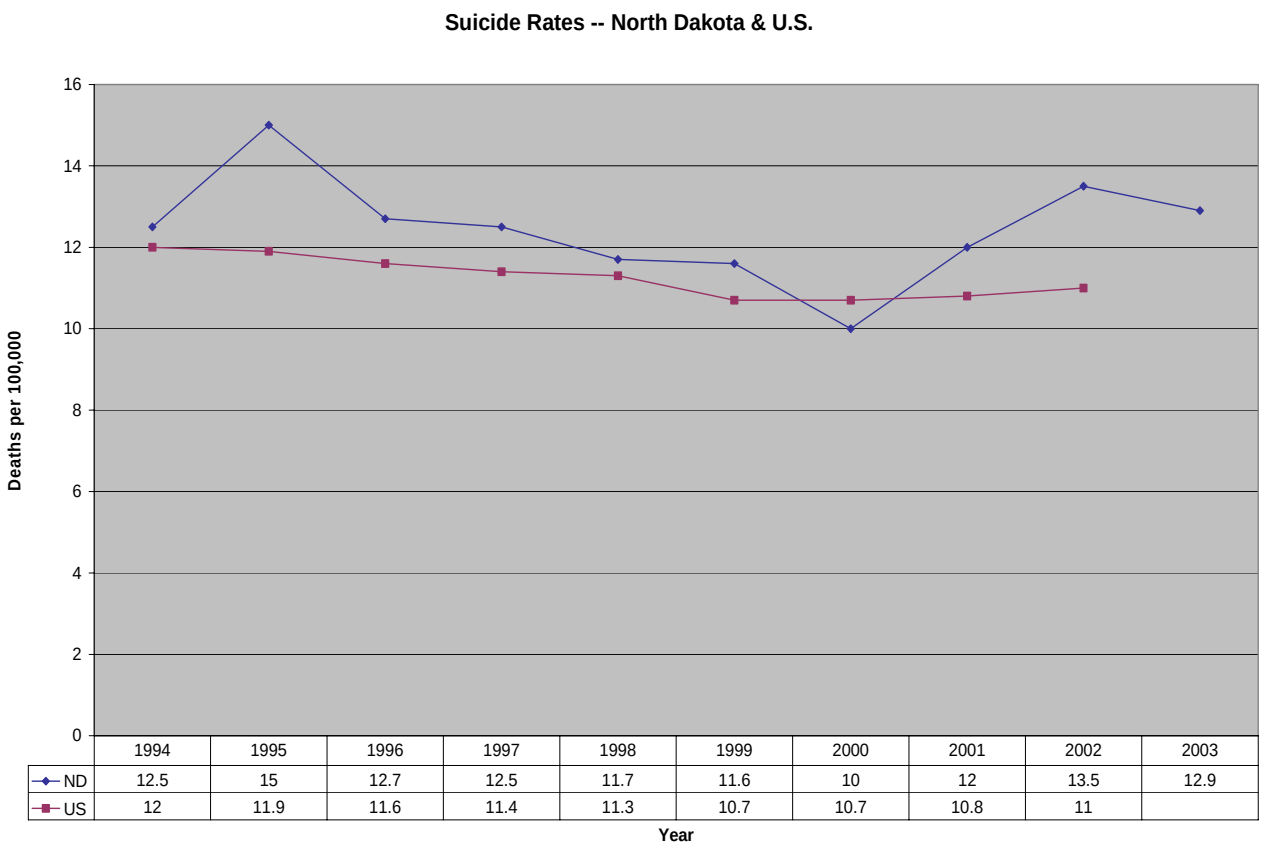


	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
ND Male	18.0	15.2	20.7	18.0	20.7	24.7	17.7	21.6	18.3	19.8	21.1	18.5	17	20.1	24.2	26.1	20.7	20.7	21.4	17.6	18.8	18.4	23.1	20.6	19.0
US Male	18.6	18.7	19.2	19.2	19.8	20.0	20.7	20.6	20.2	20.0	20.4	20.1	19.6	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9		
ND Female	2.2	1.6	0.8	1.9	2.1	1.9	2.7	2.6	2.4	1.1	2.2	5	3.4	5	0.9	4.1	4.7	4.4	2.2	5.6	2.2	5.6	4	5.3	3.7
US Female	5.5	5.8	5.6	5.4	5.4	5.2	5.4	5.2	5.0	4.8	4.8	4.7	4.6	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3		

THE CURRENT STATE OF SUICIDE IN NORTH DAKOTA

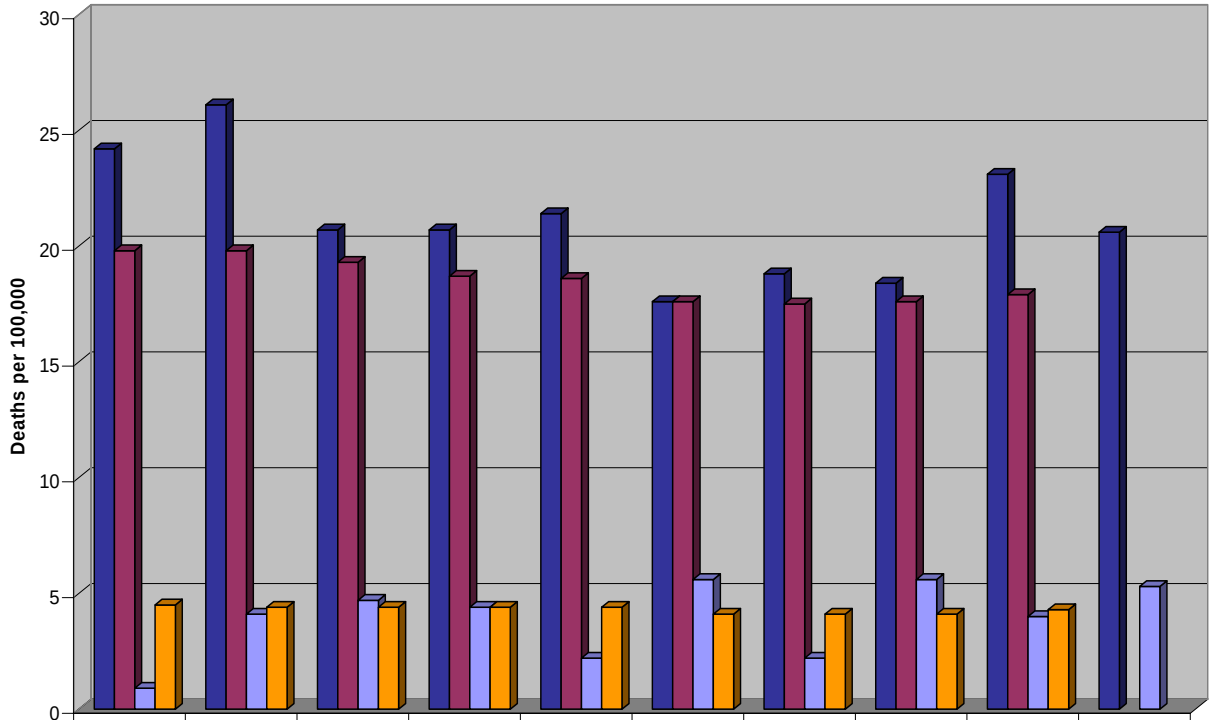
A 10-Year Comparison

The 1999 state suicide plan was focused on North Dakota's adolescents because data analysis indicated a primary need in this age group. Since the 1999 plan's inception, a four-year trend shows a 47 percent sustained reduction in North Dakota's 10 to 19-year-olds suicide fatalities. With the success of the plan in the targeted areas, North Dakota's Suicide Prevention Task Force is now experiencing the need to expand the current state plan to address goals and strategies for all ages related to suicide.



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
ND	12.5	15	12.7	12.5	11.7	11.6	10	12	13.5	12.9
US	12	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11	

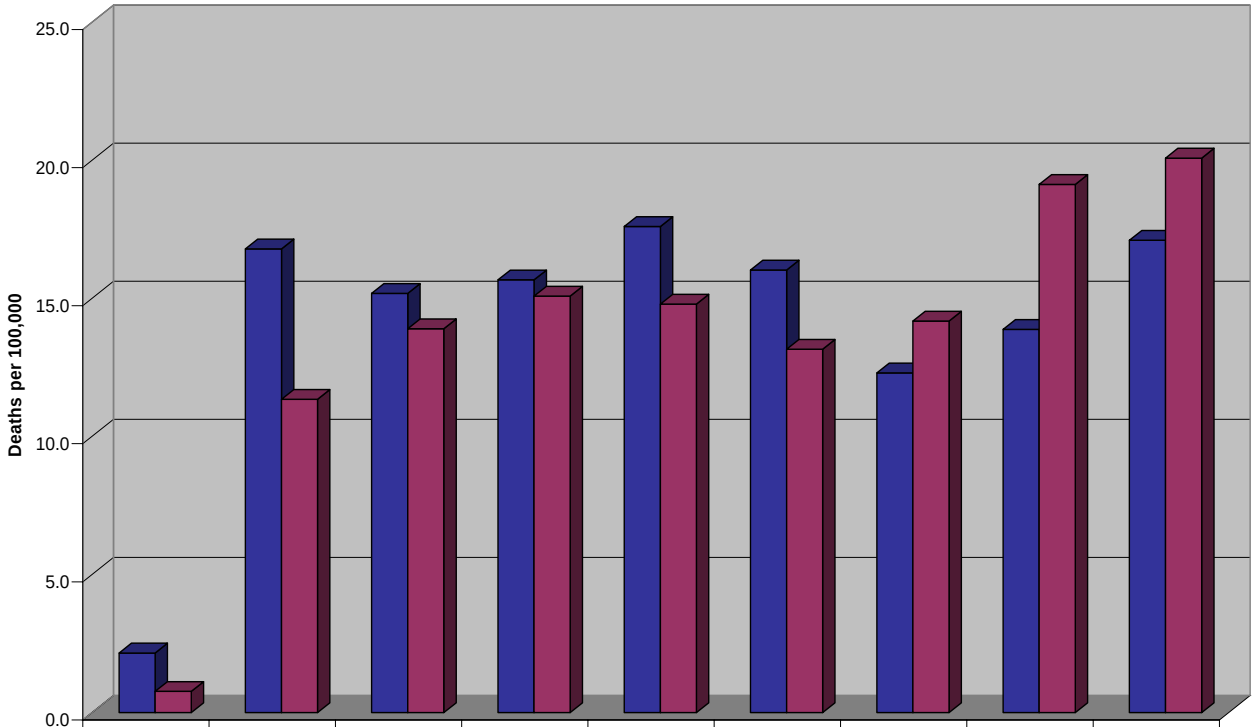
Suicide Rates by Gender -- North Dakota & U.S. 1994-2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
ND Male	24.2	26.1	20.7	20.7	21.4	17.6	18.8	18.4	23.1	20.6
US Male	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9	
ND Female	0.9	4.1	4.7	4.4	2.2	5.6	2.2	5.6	4	5.3
US Female	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3	

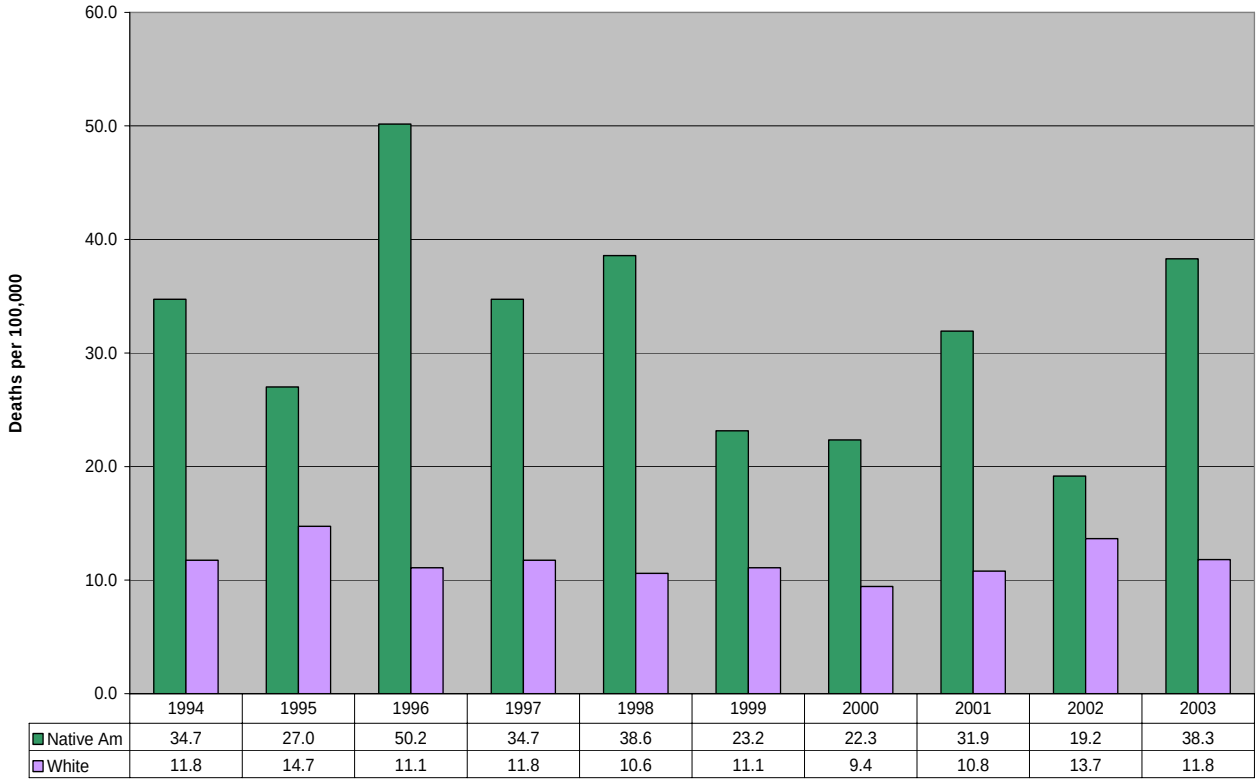
Over the last 10 years, the suicide rate of the male population in North Dakota has averaged more than five times higher than that of the female population. This difference is apparent in the U.S. suicide rates as well, only to a slightly lesser degree. Nationally, the male suicide rate is only four times higher than the female rate. On the national level, three times more females than males attempt suicide, but males tend to choose a more lethal means. While females are more likely to attempt suicide, they are less likely to succeed than males. North Dakota currently has no reporting database for suicide attempts, so it is unknown if North Dakota suicide attempts would be similar to national reported attempts.

Suicide Rates by Age Group -- North Dakota & U.S. 1994-2003



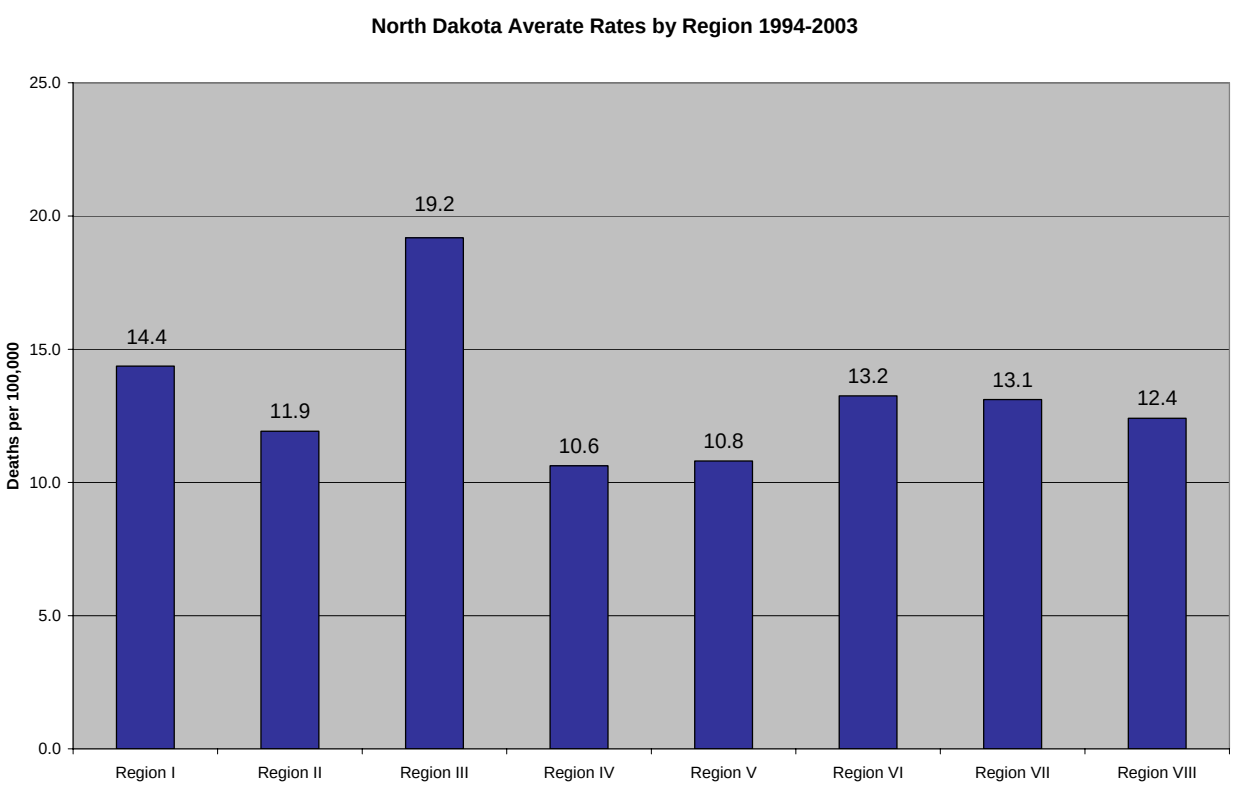
	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
ND	2.2	16.8	15.2	15.7	17.6	16.0	12.3	13.9	17.1
US	0.8	11.3	13.9	15.1	14.8	13.2	14.2	19.1	20.1

National trends show suicide rates decreasing in middle-aged adults and increasing again in the senior citizen age group. These trends are reversed for North Dakota. As a state, North Dakota is experiencing an increase in suicide rates in adult age groups, with a decrease in senior citizen age groups. The current highest suicide rate for North Dakota is 17.6 per 100,000 population in the 45 to 54 age group with a noticeable drop into the 65 to 74 (12.3 per 100,000 population) and 75 to 84 (13.9 per 100,000 population) age groups. These higher rates in middle-aged adults further demonstrate the need to expand the suicide prevention plan to encompass life span.

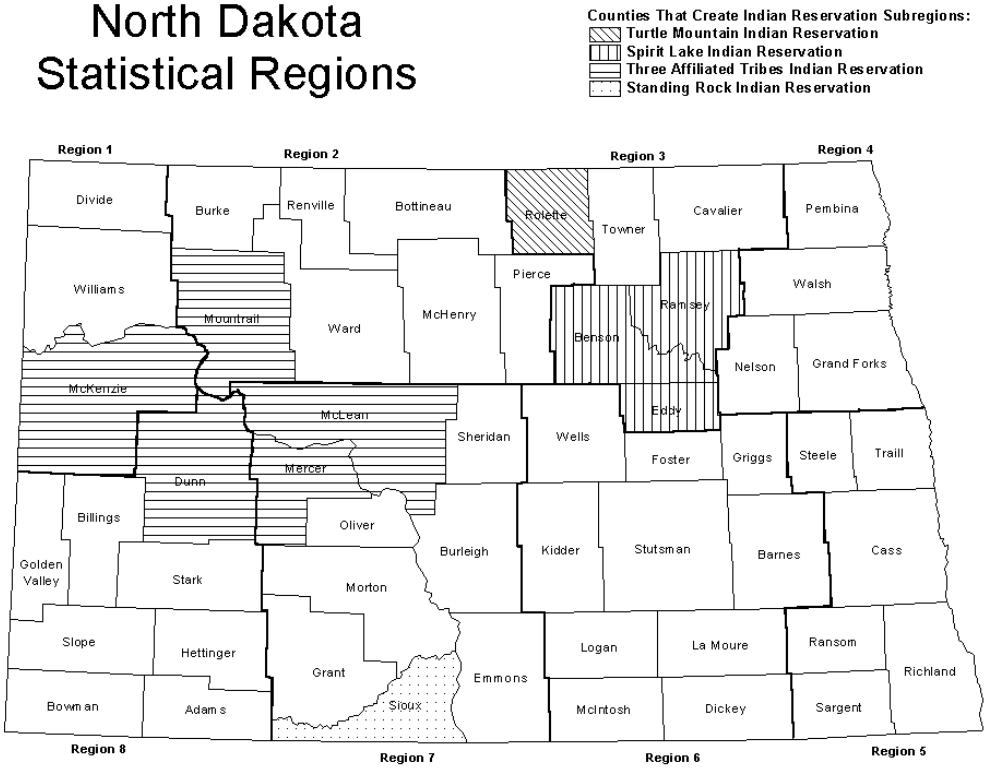


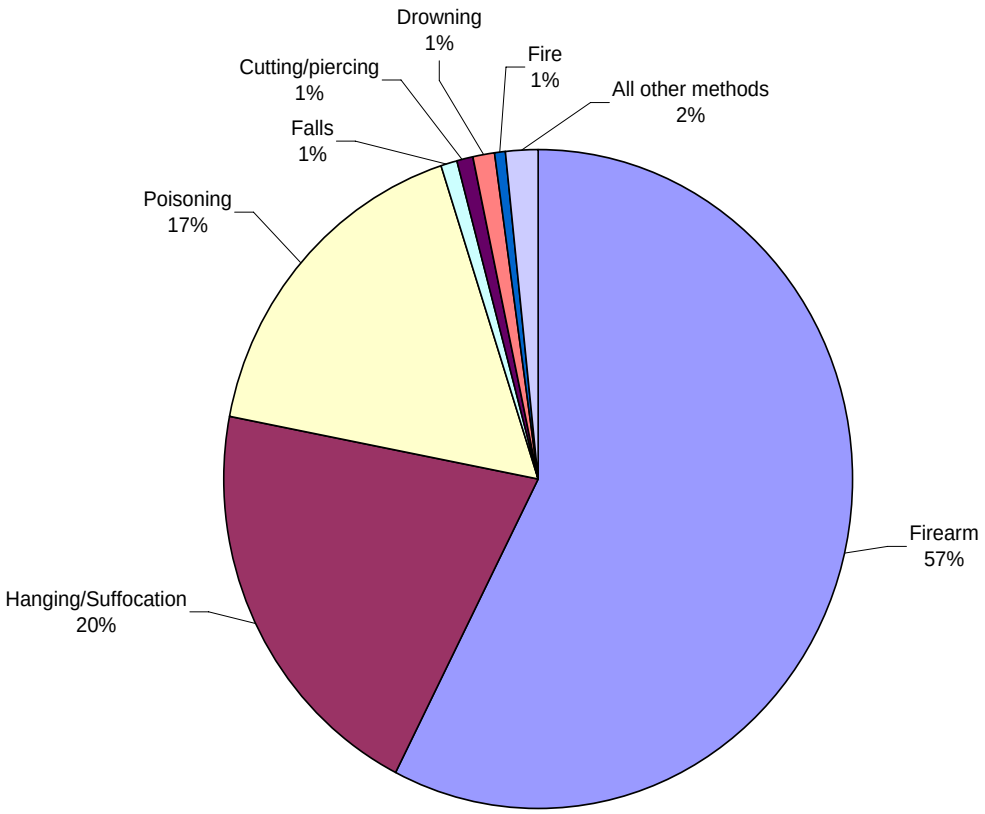
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Native Am	34.7	27.0	50.2	34.7	38.6	23.2	22.3	31.9	19.2	38.3
White	11.8	14.7	11.1	11.8	10.6	11.1	9.4	10.8	13.7	11.8

As demonstrated in the graph above, the suicide rate for Native Americans is much higher than that for the white population. The Native American 10-year suicide rate has averaged three times higher than the white suicide 10-year rate, with a difference of 32.01 for Native Americans versus 11.68 for the white population. The greatest difference in rate was in 1996 when the Native American rate of 50.2 per 100,000 population was nearly four times higher than the white rate of 11.1 per 100,000 population. This trend demonstrates a need to team with tribal leaders and implement culturally sensitive prevention efforts.



The state of North Dakota has eight governor's planning regions. This regional breakout can be better understood by consulting the chart below. As evidenced by the graph above, Region III has the highest suicide rate for the state of North Dakota with 19.2, followed by Region I with 14.4, Region VI with 13.2, and Region VII with 13.1. If we take the previous information about race into account, it should be noted that Region III, the region with the highest suicide rate, contains both the Turtle Mountain Indian Reservation and the Spirit Lake Indian Reservation. The Three Affiliated Tribes Indian Reservation is divided among regions I, II, VII, and VIII, and Region VII also has the Standing Rock Indian Reservation.





As evidenced in the chart above, 57 percent of suicides in North Dakota are by firearm. Although most gun owners reportedly keep firearms in their home for "protection" or "self- defense," nationally, 83 percent of gun-related deaths in homes are the result of a suicide. Hanging/suffocation is the second-highest method of suicide in North Dakota at 20 percent, and poisoning is the third-highest at 17 percent. Other methods included falls, cutting/piercing, drowning, and fire at 1 percent each.

THE PUBLIC HEALTH RESPONSE

Five Steps to the Public Health Approach

Leading public and private experts working in partnership to represent all who have a stake in suicide prevention developed the *National Strategy for Suicide Prevention*, released in 2001. Then-U.S. Surgeon General David Satcher M.D. released the national plan, which has become the national guide for suicide prevention efforts in the United States.

Excerpts from the National Strategy are listed below in an effort to describe how a public health approach can be used to respond to suicide at the state and community levels.

The public health approach consists of the five components outlined below. Each is described as relating to the issue of suicide and suicide prevention.

1. *Clearly define the problem.* Collecting information about suicide rates and suicide behavior is known as surveillance. Surveillance helps define the problem for the state and the community. While national data provide an overall view of the problem, the state data are key to effective prevention efforts within that state. It is very important to note, however, that annual state suicide rates, due to the fluctuations that occur in small populations, are not often useful in evaluating the effectiveness of suicide prevention programs over the short-term. Because of these fluctuations, this plan uses 10-year trend data and more long-term historical data to define the problem.

2. *Identify risk factors and protective factors.* Risk factors for suicide may be thought of as leading to or being associated with suicide; that is, those who "possess" one or more risk factors are at greater risk for suicide. Protective factors, on the other hand, reduce the likelihood of suicide, enhance resiliency and may counterbalance risk factors. Risk factors and protective factors are outlined in this plan's appendix.

3. *Develop and test interventions.* Suicide prevention interventions reduce risk and enhance protective factors. Interventions may be classified as universal, selective or indicated: a universal approach is designed for everyone in a defined population such as a health-care system, school or community, regardless of their risk for suicide; a selective approach is for groups at greater risk, such as selected age or ethnic groups; an indicated approach is designed for individuals who have been identified to be very at risk. Recommended interventions for populations in North Dakota are outlined as objectives in this plan.

4. *Implement interventions.* Suicide prevention programs are usually developed to include a broad range of interventions that are often designed to be integrated into existing programs through collaboration. Plans for program implementation can be found in the recommended activities outlined in this plan.

5. *Evaluate effectiveness.* Many interventions that are planned and assumed to prevent suicide have yet to be evaluated. Evidence-based evaluation must incorporate safety, ethics, and feasibility as well as effectiveness. Cost effectiveness also should be considered. Evaluation of this plan will be ongoing through the study of the state's data. Wherever possible, evidence-based strategies have been implemented into this plan.

THE SURGEON GENERAL'S RECOMMENDATIONS

The Surgeon General's Call to Action To Prevent Suicide, 1999

On July 28, 1999, then Surgeon General David Satcher and Tipper Gore hosted a press conference at which Surgeon General Satcher released *The Surgeon General's Call To Action To Prevent Suicide*. This document outlined recommended steps that individuals, communities, organizations, and policymakers could take toward suicide prevention in the United States. Also taking part in this press conference were Senator Harry Reid of Nevada and Representative John Lewis of Georgia, who were the original sponsors of a congressional resolution calling for the development of a national suicide prevention plan. A representative of the Suicide Prevention Awareness Network, whose partnership with the U.S. Department of Health and Human Services launched efforts to develop the national strategy, was there as well.

At a conference in Reno, Nev., the year before, researchers, clinicians, survivors and advocates came together to make recommendations for a national suicide prevention plan. More than 80 recommendations were made at that conference, which were refined to 15 essential and major recommendations. These 15 recommendations revolved around three principals – awareness, intervention and methodology – which form the acronym "AIM."

It was Surgeon General Satcher's hope that communities, policymakers, civic organizations and individuals would take the "AIM" recommendations to heart and work to implement them to prevent suicide across the United States. Outlined below are the 15 recommendations arranged according to the "AIM" categories.

At a Glance: Recommendations

Awareness: Broaden the public's awareness of suicide and its risk factors.

- Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology to make facts about suicide and suicide prevention widely and appropriately available to the general public and health- care providers.
- Expand awareness of and enhance access to resources for suicide prevention programs in communities.
- Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse and suicide and with seeking help for such problems.

Intervention: Enhance services and programs, both population based and clinical care.

- Extend collaboration with and between public and private sectors to complete a National Strategy for Suicide Prevention.
- Improve ability of primary care providers to recognize and treat depression, substance abuse and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.
- Eliminate barriers in public and private insurance programs for provision of quality mental health treatments, and create incentives to treat patients with coexisting mental and substance abuse disorders.
- Institute training for all health, mental health and human service professionals (such as clergy, teachers, correctional workers and social workers) concerning suicide risk assessment and recognition, treatment, management and aftercare interventions.
- Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to and refer people showing signs of suicide risk. Natural community helpers are people such as educators, coaches, hairdressers and faith leaders, among others.
- Develop and implement safe and effective programs in educational settings for youth that address adolescent distress and crisis intervention and incorporate peer support for seeking help.
- Enhance community care resources by increasing the use of schools and workplaces as access points for mental and physical health services and providing comprehensive support programs for people who survive the suicide of someone close to them.
- Promote public/private collaboration with the media to ensure that entertainment and news coverage represent balanced and informed portrayals of suicide and its prevention, mental illness, and mental health care.

Methodology: Advance the science of suicide prevention.

- Enhance research to understand risk and protective factors, their interaction and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals and culture-specific interventions.
- Develop additional scientific strategies for evaluating suicide prevention interventions, and ensure that evaluation components are included in all suicide prevention programs.
- Establish mechanisms for federal, regional and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors, and develop and promote standard terminology in these systems.
- Encourage the development and evaluation of new prevention technologies to reduce easy access to lethal means of suicide.

ASSETS AND BARRIERS

Several factors that could affect the implementation of this plan have been identified. These factors include assets that could have a positive and supportive impact on the implementation of the plan, and barriers existing within North Dakota's environment that could provide a challenge to carrying out the plan.

Assets

- Existing Infrastructure and Resources
  - Many communities have existing coalitions for alcohol prevention and injury prevention. Incorporating suicide within the scope of these coalitions would offer an existing basis for community involvement.
  - Models of multi-disciplinary problem-identification teams already exist at the state and community levels.

- Small Population
  - The small population base in North Dakota serves to connect people together and provides an opportunity for greater communication and networking.
  - The suicide prevention plan can impact the entire state.

- A Sense of Community
  - Many citizens are willing to get involved in their community's problems.
  - Many community leaders are supportive of the issue of suicide prevention.
  - Many communities address their problems through community coalition efforts.

- State Suicide Prevention Task Force
  - Members, individually and collectively, can and will advocate for the implementation of the suicide prevention plan, serve as a resource to their individual communities, and serve as a network to provide resource information.

Barriers

- Infrastructure
  - There is a lack of dedicated funding for suicide prevention and the implementation of the suicide prevention plan.
  - There is a reluctance to allocate existing resources to suicide prevention efforts.
  - Suicide prevention efforts compete with other public health issues for limited resources.
  - There is a lack of sufficient numbers of trained professionals and volunteers dedicated to the issue of suicide prevention, creating overburdening of human service professionals.

- Attitudes
  - There is a general lack of community awareness and acceptance of the problem.
  - There is a lack of cultural awareness and sensitivity in suicide prevention materials and programs.
  - Many communities have a lack of local capacity and insufficient expertise to guide and plan activities.
  - Actual suicide numbers within any given community are generally low; therefore, the problem is easy to ignore or dismiss.
  - Suicide prevention efforts are difficult to sustain after a completed suicide fades into the past.
  - Changes in local and state leadership often mean changes in public health priorities and agendas.

- North Dakota Uniqueness
  - Much of the state's population is geographically isolated.
  - Mental health issues are often accentuated by the harsh winter climate.
  - An ingrained social culture has accepted suicide as part of normal life through generations.
  - A lack of availability and accessibility to mental health services exists in many areas of the state.
  - A prevalent and very proud "independent" culture promotes the attitude that "we can take care of ourselves."
  - The western culture promotes the acceptance of firearms within homes, often with improper storage.
  - A lack of transportation services in remote areas inhibits the ability to seek or receive help.
  - A lack of communication services, such as cellular telephone service and Internet access, exists within some areas, including rural and frontier areas and American Indian reservations.
  - North Dakota ranks very high in alcohol and substance abuse, particularly binge drinking, when compared to other states, which can influence suicide rates.
  - The long-term rate of suicide in North Dakota has remained relatively stable, despite previous prevention efforts.

NORTH DAKOTA'S RECOMMENDATIONS

Priority Areas, Goals, Strategies and Possible Action Steps

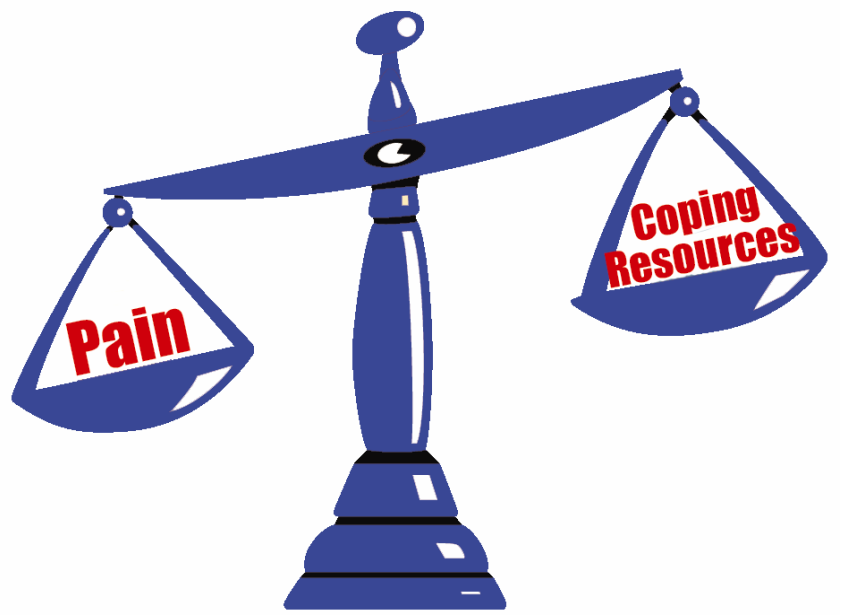
This section outlines the major recommendations and implementation strategies to reduce the incidence of suicide in North Dakota.

Recommendations are based on three primary principles:

1. Strategies should be selected using evidence-based research. The recommendations outlined in this plan are based upon a review of the Surgeon General's Recommendations and the practical and critical experience of suicide prevention experts within the state.
2. Strategies must be outlined and implemented at both the state and community levels. Communities, for the purpose of this plan, can be defined as any group of people who share biological, social and/or geographic characteristics.
3. Suicide prevention is ever changing. This plan is intended to be fluid, should be tested regularly, and should evolve as new knowledge is identified through practical experience and evidence-based reporting.

The Suicide Prevention Task Force, through a consensus-building strategy, identified four priority areas for the state suicide prevention plan. Each of the priority areas is outlined on the following pages. Goals and strategies are designed to address each priority area.

"Suicide is not chosen; it happens when pain exceeds resources for coping with pain."
— David L. Conroy, Ph.D.



"Statistics are human beings with the tears wiped away."
— Carol Meidinger, North Dakota Department of Health

Infrastructure and Systems:

GOAL: Dedicate sufficient personnel and fiscal resources to address the issue of statewide suicide prevention activities over a structured and long-term basis.

Strategy: *Have the MHAND in collaboration with the North Dakota Department of Health Injury Prevention Program continue as the lead organizations for suicide prevention efforts in North Dakota.*

Strategy: *Provide funding, training, technical assistance and other resources to communities, including tribal, to implement community-based, culturally appropriate suicide prevention efforts.*

Strategy: *Involve policymakers in suicide prevention issues, including the need for adequate funding to sustain prevention efforts in North Dakota.*

Strategy: *Develop a more efficient means of tracking suicidal behavior through expanded and linked data collections systems.*

Medical Data Recording Systems

Follow-Back Study / Tracking

Involving Policy Makers

Death Scene Investigation (CDC Protocol)

"Because we don't know what to do, we often do nothing."
— Drinda Olsen, North Dakota Department of Public Education

Education and Awareness:

GOAL: Increase education and public awareness of, and reduce the stigma about, the issue of suicide as a leading cause of death and a significant public health issue in North Dakota for all ages.

Strategy: *Provide gatekeeper curriculum to 25 percent of North Dakota's population.*

Strategy: *Provide suicide prevention, education and intervention training to 50 percent of professional groups.*

Strategy: *Implement a media campaign reaching 50 percent of North Dakota's population.*

Strategy: *Educate all policy makers with research-based information about suicide in North Dakota.*

Gate Keeper Training

Website Development

Media Campaigns

Newsletters

Professional Development

"New research indicates that suicide is not a normal response to severe distress, but the response of a person with vulnerability to act on powerful feelings."

— J. John Mann, Columbia University and the New York State Psychiatric Institute

Intervention and Treatment:

GOAL: Reduce the danger and harm of suicidal behavior.

Strategy: *Increase early identification of individuals with at-risk suicidal behaviors.*

Strategy: *Increase the number of services available to people effected by suicidal behaviors.*

Strategy: *Increase awareness of services.*

Strategy: *Decrease stigma and obstacles to accessing services.*

Strategy: *Develop statewide contagion response team.*

Hotline 2-1-1 Phone Follow-Ups

Community and School Crisis Teams

Screening Strategies

Treatment Access

Home Based Trackers

"Never deprive someone of hope; it might be all they have."
— H. Jackson Brown, Jr. Writer

Strengthening Community Relations and Building Resiliency:

GOAL: Promote assets and resiliency to all people, with attention toward building healthy relationships.

Strategy: *Develop an effective communication network among all entities involved in suicide prevention.*

Strategy: *Develop and implement school-based programs addressing resiliency and identifying and strengthening protective factors.*

Strategy: *Expand the network of mentoring programs.*

Strategy: *Improve access to, and community linkages among, primary care, mental health, substance abuse and other identified professionals and community groups and coalitions.*

Volunteer Mentors

Small Group Support

Teen-Led Prevention

Inter-generational Programs

APPENDIX A

*Suicide Prevention Facts, Risk Factors and Protective Factors**

Statewide

* From 1994 through 2003, 797 people committed suicide in North Dakota. This averages out to about 80 people per year or almost seven each month.

* Between 1994 and 2002, the North Dakota suicide rate was higher than the national average eight of the nine years.

* For the years 1997 through 2001, suicide was the seventh leading cause of death in North Dakota.

* Region III has the highest 10-year average suicide rate (19.2); the next highest rate is Region I (14.4).

* Firearms account for 58 percent of all suicides in North Dakota; more people commit suicide by firearms than all other methods combined.

* Suicide by firearms is almost three times more prevalent than the next most common method of suicide: hanging/suffocation.

* There are an average of 382 hospitalized suicide attempts per year in North Dakota, and an average of one attempt per day needing serious medical attention.

* The average medical cost per case of suicide attempt is $7,516.

* The average work-loss per suicide fatality is $780,802.

Gender

* There are almost six male suicides for every female suicide in North Dakota.

* Females account for 58 percent of suicide attempts, with a rate of 68.5 per 100,000 per year.

* Males account for 42 percent of suicide attempts, with a rate of 50.8 per 100,000 per year.

Race/Ethnicity

* Although the white population had seven times more deaths by suicide than the Native American population in the last 10 years, because of the population base, the suicide rates for Native Americans were almost three times that of the white population. In some tribal areas of North Dakota, the rate was five times higher than that of the white population.

Age

* The highest average suicide rates for 1994 through 2003 were in the 45- to 54 age group (17.6) and the 15 to 24 age group (16.8).

* Suicide fatalities increased from 17 percent to 28 percent in the 30 to 55 age group in the past four years.

* In the past four years, since the adolescent suicide prevention project started, there has been a 47 percent decrease in the 10 to 19 age group suicide fatalities, and a decrease of 35 percent in the 10 to 24 age group.

* 15- to 19-year-olds account for 32 percent of suicide attempts and have the highest hospitalization attempt rate.

2003 Youth Risk Behavior

* Of ninth through12th graders, 14 percent reported thinking of suicide in the past year, down 29 percent since 1999.

* Of ninth through12th graders, 11 percent planned for a suicide in the past year, down 20 percent since 1999.

* Of ninth through12th graders, 7 percent reported attempting suicide in the past year; attempts needing medical attention are down 20 percent since 1999.

MYTH:	People who talk about committing suicide never attempt suicide.
FACT:	Up to 75 percent of those who take their lives have talked about suicide before attempting.
MYTH:	Once a person decides to commit suicide, there is nothing that can stop them.
FACT:	Most people who commit suicide appear to be ambivalent about their own deaths. For many people, the suicide crisis passes and they are grateful for having been prevented from self-destruction.
MYTH:	Never ask a deeply depressed or troubled person if he or she has had suicidal thoughts. It may implant the idea.
FACT:	A person may feel relief if another person asks if suicide has become an issue, thus actually giving permission to talk about things that are troubling.
MYTH:	Once a person is suicidal, he or she will always be suicidal.
FACT:	Most people who become preoccupied with suicidal thoughts are suicidal for only a limited time. Many lead normal lives if they receive appropriate help for the issues and complexities in their lives.

COMMON WARNING SIGNS OF SUICIDE

- Giving away favorite possessions
- A marked or noticeable change in behavior
- Previous suicide attempts and statements revealing a desire to die
- Depression
- Inappropriate "good-byes"
- Verbal behavior that is ambiguous or indirect: "You won't have to worry about me anymore," "I want to go to sleep and never wake up"
- Purchase of a gun or medications
- Alcohol and other drug use
- Sudden happiness after a long depression
- Obsession about death and talk about suicide
- Decline in performance of work, school, or other activities
- Deteriorating physical appearance or reckless actions

HIGH-RISK LIFE EVENTS ASSOCIATED WITH SUICIDE

- Death or terminal illness of a loved one
- Divorce, separation or broken relationship
- Loss of health (real or imaginary)
- Loss of job, home, money, self-esteem or personal security
- Anniversaries
- Difficulties with school, family or the law
- Early stages of recovery from depression

WHAT TO DO

- Take suicide threats seriously; be direct, open and honest in communication.
- Listen, allow the individual to express his/her feelings and express your concerns in a non-judgmental way.
- Say things like, "I'm here for you," "Let's talk," and "I'm here to help."
- Ask, "Are you having suicidal thoughts?" A detailed plan indicates greater risk.
- Take action sooner rather than later.
- Get the individual connected with professional help.
- Dispose of pills, drugs and guns.
- Do not worry about being disloyal to the individual; contact a reliable family member or close friend of the individual

WHAT NOT TO DO

- Do not leave the individual alone if you feel the risk to his/her safety is immediate.
- Do not treat the threat lightly even if the individual begins to joke about it.
- Do not assume the situation will take care of itself.
- Do not act shocked or condemn the person. There may not be another cry for help.
- Do not point out to the individual how much better off he or she is than others are. This increases feelings of guilt and worthlessness.
- Do not swear yourself to secrecy.
- Do not offer simple solutions.
- Do not suggest drugs or alcohol as a solution.
- Do not judge the individual.
- Do not try to cheer the individual up or tell him/her to snap out of it.
- Avoid arguments or debates.
- Do not try to counsel the individual yourself; GET PROFESSIONAL HELP!

WHERE TO GET HELP

Contact your community mental health center or other suicide prevention programs.

**Adapted from the Public Information and Education Workgroup of the Colorado Governor's Suicide Prevention Advisory Commission.*

APPENDIX B

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APPENDIX C

Glossary

Activities – The specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Affective disorders – See mood disorders.

Biopsychosocial approach – An approach to suicide prevention that focuses on those biological, psychological and social factors that may be causes, correlations and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder – A mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Cognitive/cognition – The general ability to organize, process and recall information.

Community – A group of people residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans – Plans that use a multifaceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social, and environmental factors.

Contagion – A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate – A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services.

Culture – The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, faith or social group.

Depression – A constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective – Prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly – Persons age 65 or older.

Environmental approach – An approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology – The study of statistics and trends in health and disease across communities.

Evaluation – The systematic investigation of the value and impact of an intervention or program.

Evidence-based – Programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study – The collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected

supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Gatekeeper – Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal – A broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health – The complete state of physical, mental and social well-being, not merely the absence of disease or infirmity.

Indicated prevention intervention – Intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intervention – A strategy or approach that is intended to prevent an outcome or alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means – The instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Methods – Actions or techniques that result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Mental disorder – A diagnosable illness characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health – The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective, and relational).

Mental health problem – Diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Mental health services – Health services that are specially designed for the care and treatment of people who have mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals who have severe disorders.

Mental illness – See mental disorder.

Mood disorders – A term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states; included are depressive disorders, bipolar disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Objective – A specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many or how often.

Outcome – A measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs – Programs that send staff into communities to deliver services or recruit participants.

Prevention – A strategy or approach that reduces the likelihood of risk of onset, delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – Factors that make it less likely individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Rate – The number per unit of the population with a particular characteristic for a given unit of time.

Resiliency – Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – Those factors that make it more likely individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening – Administration of an assessment tool to identify people in need of more in-depth evaluation or treatment.

Selective prevention intervention – Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Sociocultural approach – An approach to suicide prevention that attempts to affect the society at large or particular subcultures within it to reduce the likelihood of suicide (such as adult-youth mentoring programs designed to improve the well-being of youth).

Social support – Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Stakeholders – Entities — including organizations, groups and individuals — that are affected by and contribute to decisions, consultations and policies.

Stigma – An object, idea or label associated with disgrace or reproach.

Substance abuse – A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substance such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) – A potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries or no injuries.

Suicidal behavior – A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts and completed suicide.

Suicide – Death from injury, poisoning or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt – A potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors – Individuals who have survived a prior suicide attempt.

Suicide survivors – Family members, significant others or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is used also to mean suicide attempt survivors.

Surveillance – The ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Universal preventive intervention – Intervention targeted to a defined population, regardless of risk (this could be an entire school, for example, and not the general population per se).

APPENDIX D

Resources

WEBSITES

www.sprc.org National Suicide Prevention Resource Center comprehensive suicide prevention information for a wide range of issues — check here first.

www.afsp.org American Foundation for Suicide Prevention with a free youth suicide prevention packet available.

www.nimh.nih.gov National Institute of Mental Health supports a large website on a variety of mental illness and mental health issues.

www.ndhealth.gov The North Dakota Health Department website – click on "Publications" and scroll to Community Health Section for the report "Suicide by North Dakota Children, Teenagers, and Young Adults — the North Dakota Response."

www.mhand.org Mental Health Association in North Dakota home page with suicide prevention and crisis intervention clearinghouse.

www.health.state.nd.us/ndhd/prevent The North Dakota Prevention Resource Center clearinghouse and reports.

www.dpi.state.nd.us/health/index.shtm School Health and Drug Free Program page from the North Dakota Department of Public Instruction, which includes data on the North Dakota Youth Risk Behavior Survey.

www.cdc.gov The U.S. Centers for Disease Control and Prevention Report on the Youth Risk Behavior Surveillance System.

www.spanusa.org Suicide Prevention and Advocacy Network sponsors national legislation and prevention efforts.

www.surgeongeneral.gov The Surgeon General's call to action on suicide prevention and Mental Health Report on Youth.

www.nida.nih.gov The National Institute of Drug Abuse has reports linking stress, suicide and drug addiction.

www.suicidology.org The American Association of Suicidology has a wide range of support information and prevention resources available at this site.

www.nmha.org The National Mental Health Association has many resources on suicide and other mental health related topics.

www.aap.org American Academy of Pediatrics has a wide range of materials for youth and parents including recent reports encouraging screening of teens for suicide.

www.ac.wwu.edu/~hayden/spsp/ Western Washington University has a site listing all of the state's suicide prevention plans.

www.ihs.gov/MedicaPrograms/InjuryPrevention Indian Health Services provides statistics, recommendations and grant opportunities regarding suicide prevention.

www.aacap.org American Academy of Child and Adolescent Psychiatry has many resources on teen suicide issues.

www.captus.org Centers for the Application of Prevention Technology have great sites bringing prevention research into practice.

www.search-institute.org Search Institute provides a variety of materials on assets for youth and research information.

www.peerhelping.org The National Peer Helpers Association provides leadership and promotes excellence in the peer resource field.

www.healthycommunities.org Coalition of Healthier Cities and Communities including success stories in the field of prevention.

www.health.org/multicul/index.htm NCADI Multicultural Prevention provides access to culturally relevant treatment and prevention with an emphasis on medical information.

www.nwrel.org National Mentoring Center is a first stop for mentoring materials.

www.mentoring.org National Mentoring Partnership provides resources and support for mentoring for America's young people.

www.yellowribbon.org Suicide prevention movement founded by the Light for Life Foundation.

SURVIVOR LINKS

www.mhand.org/support_groups/index.asp The North Dakota Support Group Internet Finder

www.afsp.org/index-1.htm Suicide Survivor Resource and Healing Guide

www.afsp.org/survivor/financial/index.html Surviving a Suicide: A Financial Guide

www.sprc.org/links/survivorlinks.asp Suicide Survivor Support Website List

www.compassionatefriends.com/Resources/resources.shtml Compassionate Friends Grief Resource Center (recommended books)

www.spanusa.org/C_suicide-resources.html Suicide Prevention Action Network Survivor Resources

BOOKS

A Message of Hope for Surviving the Tragedy of Suicide by Pat Overley

A Teenager's Book about Suicide by Earl Grollman

After a Suicide by Dougy Center

After Suicide: A Ray of Hope for those Left Behind by E. Betsy Ross

After Suicide: Christian Care Book by John H. Hewett

After Suicide Loss: Coping with Your Grief by Bob Baugher, Ph.D. and Jack Jordan, Ph.D.

Aftershock: Help, Hope, and Healing in the Wake of Suicide by Arrington Cox, Candy David, David Cox, Candy Arrington

An Empty Chair-Living in the Wake of a Sibling's Suicide by Sara Swan Miller

Assembling My Father by Anna Cypra Oliver

But I Didn't Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors by Barbara Rubel

Comprehensive Textbook of Suicidology by Ronald W. Maris

Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling by Michelle Lynn-Gust

Grieving a Suicide-A Loved One's Search for Comfort, Answers, and Hope by Albert Y Hsu

Healing After the Suicide of a Loved One by Ann Smolin

In the Wake of Suicide: Stories of those Left Behind by Victoria Alexander

Living When a Young Friend Commits Suicide by Earl Grollman

My Son…My Son: A Guide to Healing After a Suicide in the Family by Iris Bolton

Night Falls Fast: Understanding Suicide by Kay Redfield Jamison

No Time to Say Goodbye-Surviving the Suicide of a Loved One by Carla Fine

Seduction of Suicide-Understanding and Recovering from Addiction to Suicide by Kevin Taylor M.D.

Silent Grief-Living in the Wake of Suicide by Christopher Lukas and Henry M. Seiden

Someone I Love Died by Suicide: A Story for Child Survivors and Those Who Care for Them by Doreen Cammarata

Standing In the Shadow: Help and Encouragement for Suicide Survivors by June Cerza Kolf

The Suicidal Mind by Edwin S. Shneidman

Suicide: Prevention, Intervention, and Postvention by Earl Grollman

Suicide of a Child by Adina Wrobleski

Suicide Survivors: A Guide for those Left Behind by Adina Wrobleski

Suicide Survivors' Handbook: A Guide for the Bereaved and Those Who Wish to Help Them by Trudy Carlson

Suicide Why: 85 Questions and Answers about Suicide by Adina Wrobleski

Surviving Suicide: My Journey to the Light within by Mary Scovel

When Someone You Love Completes Suicide This is Survivable by Sondra Sexton-Jones

APPENDIX E

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